Sample Claim and Provider Documentation

This day care receipt contains the items the Internal Revenue Code requires:

1. It is signed by the provider of service - "Ima Sitter"
2. It contains a description of the services - "day care services"
3. It explicitly lists "5-1-99 to 5-31-99" as the range of the dates that the day care was provided.
4. It includes the amount charged for the day care "$300.00"; not necessarily the amount paid.
5. It identifies the person for whom the day care was provided - "Mike Riddick"

Day care documentation must contain all of these items in order to be processed.

I provided day care services for Mike Riddick

From 5-1-99 to 5-31-99. The total sum for services provided was $300.00.

Signed Ima Sitter
Ima Sitter
123 Main Street
Columbia, MO 65203
SSN 123-45-6789

We must be able to identify the participant

ASI

CLAIM FORM
Please read requirements on reverse side

Riddick, John M. — Last Name, First Name
ASI — Employer
111 — 22 — 4444 — Social Security Number
110 E. Ash St. — Street Address
Columbia MO 65203 — City,State,Zip

Dependent Care Assistance (day care, babysitting, etc.)

Name of Dependent	Age	Service Period From	Service Period To	Name, Address and Tax Payer Id number of Provider of Service	Charge for Services	ASI use only
Mike	10	5/1	5/31	Ima Sitter, 123 Main St. Columbia MO 65203 123-45-6789	300.00	
				Total Dependent Day Care Claim →	300.00	

I provided the dependent care as stated above — Care Provider's original signature — Date — SSAN/Tax ID#

Separate dependent care documentation is not required if the provider signs the form after the dependent care section is completed.

Medical Benefits

Date Care Provided*	Name of Service Provider	Expense Description	Name and relationship of Person for whom expense incurred	Amount that is your responsibility	ASI use only
5/15/99	I William See, M.D.	Eye Exam	Mary - daughter	10.00	
				Total Medical Amount Requested →	10.00	

Please arrange documentation in order listed above.

*Claims for future services will not be accepted.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Flexible Spending Plan with respect to such expenses and that the expenses have not been reimbursed and are not reimbursable from any other source. Any Dependent Care Assistance expenses claimed here were provided for my dependent under the age of 13 or for a dependent who is incapable of self care. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

John M. Riddick — Employee Signature
12/29/99 — Date

The participant must sign the claim form.

Every request and all documentation must contain all the items shown in blue

I. William See, MD
Ophthalmology
2020 Seymour
Crystalview, MO 65201

Service Date	Description	Charge for Services
5/15/99	Eye Exam	$10.00

Patient's Name — Mary Riddick

This health care service statement contains the items the Internal Revenue Code requires:

1. It identifies the provider of service - "I. William See, MD"
2. It contains a description of the services - "Eye Exam"
3. It explicitly states the date of the eye exam - "5/15/99"
4. It includes the amount charged for the exam "$10.00"; not necessarily the amount paid at the time of service.
5. It identifies the person receiving the eye exam - "Mary Riddick"

Medical documentation must contain all of these items in order to be processed.